(7) Rehabilitation Hospitals, Long-term Acute Care Hospitals, and Psychiatric Hospitals.

A. Hospitals covered under this section are excluded from the DRG reimbursement system and will be reimbursed under a per diem methodology. Rehabilitation hospitals, long-term acute care hospitals, and psychiatric hospitals will be paid through a prospective cost-based per diem reimbursement system based on allowable costs and allowable patient days. The per diem includes an operating component, a capital component, and, if applicable a professional component.

Using the most recently submitted cost report available as of May 1 of each year, costs will be trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on unaudited data will be revised upon receipt of an audited cost repot from the fiscal intermediary or an independent audit firm. Prospective rates include both inpatient routine and inpatient ancillary costs using and are based on the following:

1. Allowable Medicaid inpatient operating costs are determined based on Medicare cost finding principles. Medicaid inpatient operating costs as reported on the cost report are trended to the beginning of the rate year and increased for inflation by the Data Resources Index. Operating costs are divided by allowable Medicaid inpatient days to establish an operating per diem.

2. Allowable Medicaid inpatient capital costs are determined based on Medicare cost finding principles except that inpatient building and fixtures depreciation is limited to sixty-five (65) percent of the amount reported. Capital costs are not trended or indexed for inflation.

   Allowable capital costs will be reduced if a minimum occupancy factor is not met by artificially increasing the occupancy factor to the minimum factor, and calculating the capital costs based on the minimum factor. A sixty (60) percent occupancy factor will apply to hospitals with 100 or few beds, and a seventy-five (75) percent occupancy factor will apply to hospitals with 101 or more beds.

3. Allowable Medicaid inpatient professional costs are determined by the Data Resources Index to project current year costs. A professional cost component is computed by dividing Medicaid professional costs by Medicaid allowable days.

4. Provider taxes will be included as allowable costs.

5. Unallowable costs are to be reported on a Supplemental schedule and include:

   a. Costs associated with political contributions.

   b. The costs associated with legal fees for unsuccessful lawsuits against the Cabinet. Legal fees relating to successful lawsuits against the Cabinet will only be included in the period in which the suit is settled after a final decision by the Courts or by agreement by the parties involved.

   c. The costs for travel and associated expenses outside the Commonwealth for conventions, assemblies, etc. or related activities. Costs (excluding transportation) for educational purposes will be allowable costs.

Cost reports and all supplements are to be submitted annually within five (5) months after the close of the hospital's fiscal year. Extensions will not be granted. The Department will suspend payments until an acceptable cost report is filed.

B. Additional Provisions for Psychiatric Hospitals

Psychiatric hospitals will have an upper limit established at the weighted median of the array of allowable costs for all participating psychiatric hospitals. Hospitals having a Medicaid utilization of thirty-five (35) percent or higher will have an upper limit established at one-hundred and fifteen (115) percent of the weighted median. There will be no limit on depreciation.

C. New Providers/Change of Ownership

If a hospital undergoes a change of ownership, the new owner will be reimbursed at the rate of the former provider. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs data, the department will base its prospective rate on a partial year. The partial year data will be annualized and indexed appropriately.

Until a fiscal year end cost report is available, newly constructed or participating providers will submit an operating budget and projected number of patient days within 30 days of enrolling as a provider. A tentative rate will be set based on data with a final rate determined after receipt of an audited cost report. The limitations described under this section will apply.

For a newly enrolled provider in a non-rebase year, costs and per diems will be trended and indexed to the base year to establish a base year per diem. The base year per diems will then be adjusted to account for historical inflationary rate increases received by other providers. For example: A provider participating for the first time in SFY 2003 rates would be based on current costs which would be trended back to 1997 to correspond to the base year costs for other providers. After determining the base year costs, costs would be trended and indexed to 1998 to establish a prospective rate for 1998. From 1998 to the current rate year, the 1998 rate would be adjusted in the same manner as other providers; i.e. in 1999 a 3% rate increase; 2000 a 2.8%rate increase; 2001 rates were frozen; 2002 rates were frozen, etc.

D. Out-Of State
An out-of-state rehabilitation hospital, psychiatric hospital, or critical access hospital will be reimbursed for an impatient service on a fully prospective per diem basis for the universal rate year beginning on or after April 1,2003. The per diem rate will be the median per diem rate for the appropriate classification of hospital. The median will be calculated at the beginning of each universal rate year.

E. For the universal rate year April 1, 2003 through June 30, 2004, rehabilitation hospitals, long-term acute care hospitals, and psychiatric hospitals will continue to be paid the per diem in effect for the rate year beginning July 1, 2002.

(8) Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital is a hospital that (a) has a Medicaid utilization rate of not less than one percent; and (b) has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision shall not apply to a hospital that did not offer non-emergency obstetric services as of December 21, 1987.

B. Hospitals shall be classified as follows:

1. Type I hospitals shall be hospitals with 100 beds or less;
2. Type II hospitals shall be hospitals with more than 100 beds that are not Type III or Type IV hospitals;
3. Type III hospitals shall be state university teaching hospitals; and
4. Type IV hospitals shall be state-owned mental hospitals.

C. Annually, the Department shall determine a sum of funds to be allocated to each classification of hospitals in accordance with state and federal law.

1. Non state-owned acute care hospitals are allocated 43.92% of the total federal/state allotment. (Type I and Type II hospitals)
2. State university teaching hospitals are allocated 37% of the total federal/state allotment. (Type III hospitals)
3. Mental hospitals (including private and state-owned facilities) are allocated 19.08% of the total federal/state allotment. (Type IV hospitals)
4. Any funds not distributed in any pool due to the limit in K may be transferred to another pool and distributed according to the provisions below.

D. Disproportionate share hospital payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which patient and cost data used in the calculation was taken.

E. The Department shall use patient and cost data from the most recently completed state fiscal year. DSH payments shall be made on an annual basis.

F. Distributions to a Type I and Type II hospital shall be based upon each hospital's proportion of indigent costs determined as follows:

$$\frac{\text{Indigent Costs}}{\text{Total Indigent Costs}} \quad \text{X} \quad \text{Available Fund} \quad = \quad \text{DSH Payment}$$

Indigent costs shall be the inpatient and outpatient costs of providing care to indigent patients. Indigent patients include patients without health insurance or other source of third party payment with incomes below 100% of the federal poverty level.

G. Disproportionate share hospital payments made to Type III and Type IV hospitals shall be based upon each facility's historical percentage of uncompensated costs as applied to current patient and cost data. Payments made to a Type III hospital shall be equal to the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made. Payments shall be subject to a reduction based upon available funds. Payments shall be made on an annual basis.

H. I.Except for State Fiscal Years 2004 and 2005, payments to Type III and Type IV hospitals shall not exceed the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made. For State Fiscal Years 2004 and 2005, payments shall not exceed the limitation in K.

I. *Indigent patients* include patients without health insurance or other source of third party payment with incomes below 100% of the federal poverty level. *Uninsured patients* are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

J. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

K. Limit on Amount of Disproportionate Share Payment to a Hospital.
Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. *Medicaid shortfall* is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan. The *cost of services* to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. *Uninsured patients* are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

L. Funds not distributed under the above provisions due to the limit in K. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days
Total Medicaid Days X Remaining Funds = DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). *Medicaid days* shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

M. For state fiscal years beginning July 1, 2003 and July 1, 2004, payments to public hospitals may not exceed 175% of a hospital's uncompensated care costs as described in K.

N. For dates of service beginning December 1, 2003, a hold-harmless payment will be added per paid claim for inpatient hospital services and all relative weights were increased by 2%. These changes were made in response to a settlement agreement between the Department and the Kentucky Hospital Association regarding a potential lawsuit based on DRG payments to acute care hospitals within the state. Additionally, base rates will be adjusted for sole community hospitals to the Medicare base rates in effect as of December 1, 2003. A lump sum payment was made to hospitals in the Passport region of $1.8 million as a negotiated portion of the settlement. Total payments under the settlement agreement will be approximately $20 million.

The adjustments will be in effect until April, 2004. At that time all rates will revert back to payments made prior to December 1, 2003. All payments made to hospitals under the adjusted rates will be calculated. If any additional funds remain of the original $20 million settlement amount, a lump sum payment will be made to each hospital based upon the number of claims and settlement amount calculated for each hospital. The add-on payment does not apply to transplant claims or claims that are paid at $0.00.

The hold-harmless add-on payment has been determined by calculating the cost coverage of all acute care hospitals. All hospitals which were determined to have a cost coverage below 72% will have an add-on payment calculated which would bring them up to that level. A facility-specific amount has been calculated and divided by the average number of claims for the time period in which the payout will be made. The amount will be added per claim to bring them to an annual cost coverage of 72%. It was determined that two hospitals received over 100% of their costs. These two hospitals will receive a facility-specific decrease per claim to bring them to 100% of costs.